MEDICAL CERTIFICATION FORM

Employee Name:	Date:
Unit:	
Job Title:	
Telephone Number:	SS#

The following information is needed to assess the employee's request under the Americans with Disabilities Act.

Type of Prognosis: (Please explain in detail)	
Is this Condition: _____Temporary _____Permanent	
Date the Condition Began:	Date of Return to Work:
Does this condition allow the employee to perform the Essential Functions of his job? ____ YES ____ NO	
If not, please describe what type of accommodation is needed for which essential function.	
Other Comments:	

Employee's Signature:	Date:
Supervisor's Signature:	Date:
Health Care Provider's Signature:	Date:

Youth Services
Central Office ADA Coordinator
P. O. Box 66458
Baton Rouge, LA 70896